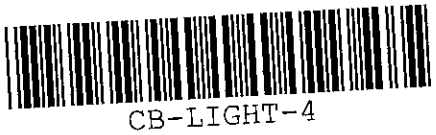

EXHIBIT J

UNITED STATES DISTRICT COURT

DISTRICT OF NEW JERSEY
10-3950DRD

DISABILITY RIGHTS NEW JERSEY, INC., et al.,

Plaintiffs,

vs.

JENNIFER VELEZ, in her official capacity as Commissioner of the New Jersey Department of Human Services, et al.,

Defendants.

DEPOSITION OF:
DR. ROBERT EILERS

Monday, March 26, 2012

Reported By:

LISA FORLANO, CCR, CRR, RMR

REF: 7005

COPY

A No, I do not.

Q Did you do anything else other than what you've already described to ensure that the procedure was working?

A If I -- you know, if I found any issues I would do training. We would discuss -- we would have monthly meetings with the medical staff, the psychiatric staff and we would talk about these issues.

Q You've mentioned trainings a few times. What trainings were conducted, as far as you can recall?

A I think it was mostly with the medical staff. It was at the monthly meeting of the psychiatry staff. There were other discussions with the treatment team staff, I remember. I frequently conducted what we called clinical reviews, which was a meeting with a team regarding particular patients and many of these patients were patients who were on the refusing status, as we have referred to it, and we discussed all the issues around the patient's reason for refusal and what treatment alternatives we could provide.

Q Okay. So I understand that there

legal, all of those issues and there is a certification, oral exam and written exam, similar to board certification for other subspecialties that you can obtain. And so I was very interested in the administrative issues at that time and the legal issues. So I applied for that and I later went on to get the board certification in forensic psychiatry as well.

Q All right. That's very helpful. And so you said that you pursued the certification in administrative psychiatry and how, then, did you receive the promotion to Medical Director at DHS?

A Well, I applied for the position. I was interviewed and was accepted for it.

Q And what are your roles and responsibilities today as the Medical Director at DHS?

A I report to our Assistant Commissioner and basically again oversee the clinical aspects of all inpatient and outpatient treatment program. By "inpatient" meaning our five-state psychiatric hospitals, and also the services that we contract for in the community with various hospitals and outpatient programs. I deal with some of the issues

mentioned?

A Well, I'd have to think about it, but I'm sure there are. There are a lot of other issues, but I think I've mentioned the main issues.

Q And you also, I think you anticipated one of my other questions, which is, have your job responsibilities changed at all over the years and I know you mentioned two things, one is the merger with Addiction Services, and I guess upcoming issues with the Medicaid managed care organization, RFPs, et cetera?

A That's correct.

Q Are there any other changes in your responsibilities, large scale changes over the years?

A I could just say in general, because of the increased shifting -- the Olmstead lawsuit and the shift towards community services, we are closing one of our State hospitals, Hagedorn Psychiatric Hospital, as of this June. And we have been for -- ever since I've been at the division, moving towards enhanced and greater services in the community to support people and not -- and reduce the size, the census at the State hospitals, which we have done.

And also towards a more patient centered recovery and wellness focus. Ever since 2007, our former Assistant Commissioner has put us in the direction of wellness and recovery transformation initiative and -- so we're trying to provide much more patient centered services.

Q Any other major changes in your responsibilities other than the ones you've mentioned?

A No, I think that's it.

Q Backing up a little bit. I know that you mentioned that Karen Piren is one of your direct reports; is that correct?

A That's correct.

Q Do you have any other direct reports?

A Yes. I have another -- Karen Piren is the psychiatric advanced practice nurse.

We have another psychiatric advanced practice nurse, Debbie Klaszky, who is, I mentioned, our older adult person who does the PASR reviews.

We have a coordinator for our SSPRC processes and we call that in the central -- in our -- in central office we call it the clinical assessment and review panel, the CARP, and Jack

other issues around medication practices. And as I said, we do have -- pharmacists also attend this meeting. So they have issues to bring up there as well. We have a chief pharmacist at the Division who meets with us. She's concerned about cost issues of medications and things like that. And that is -- so that's a regular agenda item. We generally talk about current issues that are of import like right now the merger, the issues around the ASO, but a lot of the issues are specific to the hospitals. One hospital will have issues that they want put toward. Staffing is one issue we've talked recently a lot, hiring of psychiatrists, hiring of other clinicians. Since we're going through this closing of one hospital and this general downsizing and a lot of concerns about having adequate staff, qualified staff, we talked about training -- trainings that we're we want to put on together. And usually, or oftentimes, we'll have centralized training with some of the hospitals requesting the training. We'll have -- we have some staff in the Division presenting to us on issues of their concern.

John Whitenack is the Director of the

changes to the policy at the monthly meetings?

A Well, I don't know if you could -- I mean, I don't know if you could be more specific in terms of there have been general discussions about changes in the policy in relation to enhancements that we saw were necessary around the three-step procedure, for example.

Q What else?

A We have talked about some of our -- again, I mentioned emergency certification procedures since we had that lawsuit and implemented a change in that procedure, both in terms of the procedure and the documentation and the review process, that was -- that was a discussion. We talk -- we talk also about medication issues as they relate -- they may relate to the AB:504.

Q What do you mean by that? Or perhaps give me an example.

A Well, some of the issues of the 504 involve -- of course, they involve the involuntary non-consentual use of medication and if a patient refuses, we will have to, at times, for an antipsychotic, utilize an IM, antipsychotic, and we'll talk about the type of IM that might be the

appropriate or safest, for example, or how this might be utilized. And we have a lot of discussions about medication in general, mostly from -- that is given consentually in terms of medication practices.

Q Okay. So going back to just to conversations about changes to AB:504 as it relates to involuntary medication, you mentioned enhancements to the policy, you mentioned discussing the manner of administering involuntary medications such as IMs. What else do you recall discussing in terms of potential changes to that policy?

A Well, I mean, I think it's -- we talk about the procedure itself in terms of the three steps, how the steps are carried out through the psychiatrist initially indicating the need for medication, the team meeting, the role of the RENNIE advocate at the hospital, the determination made by the Medical Director or designee and the review of that procedure. We have, at times, touched on various aspects.

Q What do you mean when you say the review of the procedure that at times you've touched on various aspects?

A I'm saying the review of the procedure

by the RENNIE advocate and how that -- you know, how that is consistent with the policy and how we can, from a quality improvement basis, how we can improve that process to ensure that. As I mentioned, we are moving towards more of a patient focused recovery oriented approach and we want to ensure that -- this is both in all aspects, particularly in regard to treatment planning, all of our hospitals have initiatives around treatment planning and medication is one part of the treatment plan, how the medication can be provided so that the patient's wishes, the patient's concerns are addressed. And hopefully a treatment plan can be developed that would both meet their treatment needs and also, you know, their goals for recovery.

Q Okay. And so I think you may have -- you may have already addressed that, but I just want to make sure I have it. When you say patient center recovering wellness, how do you define that?

A Well, we as treaters have a view of patients having a disease and wanting -- having a need for treatment. But patients themselves are consumers. We call people mostly in the community, although in the hospital we tend to use both terms.

They have their own goals and their desires for themselves and what a recovery means. They're not just looking at, you know, getting rid of symptoms or changes in their behavior, they're looking for their goals in their life, what they want for themselves. And their recovery is specific to their own desires and needs. So we try to say to them, what are your goals, and we try to align those goals with the treatment goals so that hopefully people don't have to be in the hospital, you know, very long and they can have a productive life in the community. We try to have that be the focus of treatment, not just, you know, symptoms and behaviors and the usual things that we think about when we think about clinical programs.

Q Thank you. That's very helpful.

Turning back to the discussions that you've had about potential changes to AB:504, I think one of the things that you mentioned is discussions of enhancements to the policy. What do you recall discussing about enhancements to the policy?

A Well, one of the enhancements had to do with the process in terms of the three steps,

ensuring that the three steps are -- are completed, as required by the AB, that there be the initial discussion with the psychiatrist, with the patient, that looks at the patient's treatment plan, the patient's own goals for treatment, as I said, and any alternatives that are available are considered. Alternatives of a less restrictive nature, the medications, but if medication is seen as necessary, any alternatives the patients might agree to and consent.

Then the second step we've looked at the involvement of the RENNIE advocate to ensure when the patient meets with the team that the RENNIE advocate has had a chance, at least to talk to the patient, and offer assistance, and be available for that meeting with the team and that that second step not take place until that occurred. We've also looked at in terms of the Medical Directors and designee issue who is going -- who is doing the reviews and made sure that, you know, we have -- we have had staff that if the Medical Director can't do the review, and the Chief of Psychiatry can't do the review, in those limited times that the other staff would do it are limited to those who are very

knowledgeable of the procedure. And although that was occurring in our hospitals, we just wanted to make sure that that continued to occur, and that there was an understanding that the documentation was very important.

We wanted to make sure that the documentation was completed so that anyone looking at that record, particularly the RENNIE advocate's review, would see that the steps were followed completely and that there was full documentation about each of these aspects I mentioned, and then that there would be a good working relationship between the RENNIE advocate and the Medical Director of the facility, that there be frequent communication, there be discussion of the individuals who are on refusing status. There -- and that there would be issues in case if we were looking in some instances for an IP, if the RENNIE advocate felt there was a need for an IP, that the Medical Director would assist the RENNIE advocate with that and if necessary, the division would assist in assisting with IPs. We've looked at those issues because of some past difficulties obtaining IPs. So we've looked at all of those aspects,

Q I think a second issue that you mentioned that came up in terms of potential changes to AB:504 was whether the RENNIE advocates had a chance to speak with the patient, I guess in advance of the treatment team meetings; was that correct?

A That's correct.

Q And why was that an issue that came up for discussion?

A Well, I don't remember specifically why that came up for discussion except that in I know my discussions with Karen Piren and the RENNIE advocates themselves, and understanding the requirements of the RENNIE procedure, the whole focus of having a RENNIE advocate is to ensure that those patient preferences are heard and we know there is an imbalance of powers in some ways where the patient and a treatment team, a physician, a person of authority, and we felt that having the RENNIE advocate just as having a family member or someone else that they could have present, would kind of rebalance that. And so we wanted also to have that early discussion with the RENNIE advocate so that any treatment issues that we needed to be aware of we'd be aware of right away before the

treatment started, rather than just having, you know, the RENNIE advocate involved after -- after those -- the second or third step occurred. We wanted them to be involved upfront. We felt it would just be a way of adding, as I said, something to the procedure I think that was not specifically stated, necessarily, in the 504, but was in the spirit of the 504.

Q Okay. So is it correct, then, that there were times, I guess, before these discussions took place where the RENNIE advocates were only brought into the process either after the second or third step had been completed in AB:504?

A They received notification, but I'm not sure whether they -- in every instance I'm sure they didn't. They had the opportunity, you know, to see the patient beforehand, before the second or third step took place.

Q Okay. And again, I'm paraphrasing just a little bit, so tell me if I'm getting any of this wrong. One of the reasons that you all wanted to bring the RENNIE advocates in earlier, like prior to the treatment team meeting, was so that they could, I guess, help ensure that the patient's goals or

order to establish these meetings in a timely way, may prevent some of the members of the team from being there. We want this to be as many members of the team as possible and certainly, the psychiatrist, nurse and another member of the team, and then we want the Medical Director's review to -- you know, to thoroughly -- to have that face-to-face evaluation and to have the rationale described and clearly written as to why the refusal was overwritten.

We also are, and along with that, instituting a 90-day review of RENNIE procedures. So if someone is on 90 days, that there will be another clinical review by the Medical Director to ensure that, at that point, the patient is still not refusing and the medication is necessary and meets the criteria.

Q Is the 90-day review that you just described, a part of AB:504 or part of a new revised policy?

A Well, it's one of the enhancements of the policy.

Q But is it an enhancement to AB:504 or is it part --

BY MS. WELLS:

Q Do you recall that remark?

A I'm saying I recall that in discussing the reasons why we're enhancing the process and the due process, hopefully protecting the due process rights of patients, that that discussion said in some instances the due process rights are protected by attorneys and we've had discussions. I mean, I think some of our staff are very knowledgeable and I don't remember specifically, but I'm saying I'm sure the issue came up in a discussion of the RENNIE process and what alternatives exist.

Q Setting aside any conversations that you've had with Miss Sciaston, or other attorneys, are you aware of anyone at DHS who supports the idea of providing counsel?

A No.

Q What's your opinion as to whether or not counsel should be available?

A Well, I'm somewhat aware of what goes on, just from reading, not from any direct knowledge, but my belief is that a clinically-driven process is superior because these are often complex decisions and I don't feel that a clinically-driven

process, as long as there is protections as we have in our system and we're going to have even greater in the future, in the near future with this new procedure, I don't think that a legally-driven process with a hearing substantially would change the final determination and I think would add a layer of bureaucracy and potential delay and really take away from the negotiation. I think the give and take with -- you know, over the treatment plan and the -- as I mentioned, this recovery-oriented focus we're trying to do, I think we want to -- I think it's preferable to be a clinically-driven process, as long as, you know, you have the adequate protections in place, which we feel with our new procedure, more than ever, these will be in place.

Q Have you ever worked in a state where counsel was provided to folks who were going to be involuntarily medicated?

A No.

Q You're aware that patients have counsel present at commitment hearings, correct?

A Yes.

Q Is there a reason that you think it should be different for involuntary medication

hearings or proceedings?

A Yes, I think -- I think one reason I can think of, I mean, obviously a civil commitment, involuntary hospitalization is a, you know, major restrictions on that person's autonomy and I think requires a hearing. And I think -- I don't think, though, that a legally-driven process where there would be hearings about medications would be -- are necessary if there can be a clinical process that can drive that, as long as there are adequate enhancements. I think the -- to me it's not just the decision to medicate, it's what happens after the decision. Whether that person, as I mentioned, who has recovery goals, who has their own preferences about treatment, their own short and long-term goals for recovery, how that is carried out. And I think a clinically-driven process is superior, rather than to insert another hearing and to involve -- make this a legal issue fully, that as long as the patient's due process rights are protected in that determination, that that is superior. It won't add to delays and add this layer of bureaucracy that takes the decision out of, you know, out of that discussion between the patient and

the team, which is so critical, that need for engagement is so critical to their eventual recovery and discharge from the hospital.

And I'm not aware of how the legally-driven processes really changes the outcome substantially, but I'm concerned that it could add to these -- these issues, these issues of delay, issues of -- you know, making it more of a legal process than a treatment-driven process.

Q You're familiar with the process for commitment hearings, correct?

A Yes.

Q How long does it take from start to finish for a typical patient who is going to be committed?

A It can vary considerably. I mean, we've had hearings that can go from just a few minutes, if it's a recommitment, if there's a person has been at the hospital where they've clearly still require a commitment, or it can last much longer, particularly if somebody who has been in the hospital, you know, under -- we have individuals, for example, with characterological disorders who don't -- may not as clearly meet some of the

Q Okay. Do you think that the use of psychotropic medications on an involuntarily basis restricts the autonomy of a patient?

MR. LEYHANE: Object to form.

You can answer.

THE WITNESS: I'm not sure what you mean by "autonomy" in that -- in that question.

BY MS. WELLS:

Q Okay. I was trying to use a word that you used a few minutes ago.

A Okay.

Q And so how did -- what did you mean when you said "autonomy" a few moments ago?

A Well, autonomy is the person's ability to make decisions for themselves, and I think oftentimes medication can improve their autonomy if they can't make decisions for themselves because they're having delusional thinking or they're having frequent hallucinations or, you know, as a result of their behaviors they are being confined or in some cases even, you know, restrained or secluded. These obviously take away from their autonomy. So it's hard to say. Medications do have side effects that

they are -- many of them are sedating. Many of them are -- you know, they have side effects which can restrict their autonomy if they -- if they need treatment for those side effects, they're not necessarily able to fully manage for themselves in an independent setting, if they need that treatment. Usually these are short-term issues. But I would say -- so it goes both ways, but generally medication improves patients' autonomy. And I think that's our goal with patients is to have maximal autonomy.

Q Do you think that's also the case when a patient is legally competent to make their own medical decisions?

MR. LEYHANE: I'm sorry, does he think it's the case when?

MS. WELLS: The patient is legally competent to make their own medical decisions.

You can answer.

THE WITNESS: I'm sorry, what is the case when they're legally competent?

BY MS. WELLS:

Q I'm sorry, so you were describing the pros -- the balancing of the effects of personal

autonomy when psychotropic medication is used.

A Right.

Q Is that affected, the balance that you described, by the fact that a patient is legally competent to make their own medical decisions?

MR. LEYHANE: Object to form. I don't know that the -- go ahead.

THE WITNESS: I don't know. That to me is a legal issue and I'm a clinician. Although I have some understanding of the legal issues, I'm -- I'm not clear about the question and how, you know, how I can clarify whether -- whether that person, who is legally competent -- we presume every patient to be legally competent, so -- unless, of course, they have been adjudicated incompetent and they have a guardian, I think this is the way we approach addressing patients, you know, and their autonomy.

BY MS. WELLS:

Q So assuming, then, that they're, in your view, legally competent, because that's the assumption, does it limit a patient's autonomy by being forced to take medication that they don't

a little cumbersome, but yeah, we -- it would probably replace 504. Whether it would be 504 or not, we might want to number it differently so people understand that it's not the 504.

Q Well, for the purposes of the deposition today, will you be comfortable if I refer to it as the new policy or the proposed policy?

A That's fine.

Q Okay. And you'll understand that this is the document, Exhibit 45, that I'm referring to?

A Yes.

Q Because I agree, the full title there might be a little cumbersome for us both. Okay.

So backing up a bit, was there a working group or another group of folks who were involved in drafting this document?

A It was an informal group and consisting of our attorneys. Basically, lead my Miss Sciaston, Lisa Sciaston; the Director of State Hospital Management, who I mentioned earlier since he oversees all the State hospitals.

Q Is that Mr. Whitenack?

A Mr. Whitenack, yeah, John Whitenack; Karen Piren, myself, and also working with our

Attorney General's office.

Q Anyone else?

A Well, we've consulted with others, certainly with the RENNIE advocates. We've consulted with the managing physicians, as I mentioned. They have had input, and we've consulted with our hospital CEOs, our Nursing Administrators, basically Directors of Nursing at our hospitals since much of the role falls on the nursing staff. They've all had input, but they weren't in that -- the workgroup that met to discuss the issues with the specific formation of the policy.

Q Okay. So fair to say the RENNIE advocates, the CEOs, the nursing administrators were ad hoc, they were ad hoc participants in the working group?

A That's correct.

Q Okay. And as for the regular participants that you listed, did you all meet on a regular basis? How did you come together to draft the policy?

A Well, we had meetings, but we also had a lot of discussion between meetings. I don't think we had regular meetings per se where we established

individual who started the process out and said, okay, we should sit down and look at revising this policy or how did it come about?

A I think -- I don't know if there was a specific individual because we had a lot of discussions and I don't know if it came specifically from the legal side -- I assume it came from the legal side because I wasn't -- although I was aware of the process in Corrections from having discussions with them over the years, I didn't know much about it. And the I believe one of our attorneys, and I don't remember specifically who, talked about this. We started to look into -- I was -- I said I would look into it. And as I mentioned, I was in contact with the Department of Corrections and I did eventually make arrangements to actually participate or sit in on one of their medication review hearings to review their policies, to talk to some of their managing psychiatrists, and then to bring that back to your staff.

Q I want to turn to the meetings that you mentioned with the Department of Corrections in just a moment, but going back to your working group, how frequently did you all meet to discuss the policy,

say?

A I think some time around there. I can't remember specifically when we first put the draft together or we started to put this down. We talked about the issue, for example, with the Client Service Representatives, our RENNIE advocates. We've been talking about this for a while. That our RENNIE advocates are not clinicians, yet they're given a lot of responsibility in terms of ensuring this process occurs, and we talked about somehow having a clinician, who was -- who was knowledgeable of the medication practices. And so we have had discussions, Karen Piren is very -- is -- as a psychiatric advanced practice nurse is very familiar with the training and the requirements for the psycho pharm certification for advanced practice nurse, so we talked about the potential for hiring APNs, the staff -- the recruitment issues that would entail versus an RN. We did have an RN work as a RENNIE advocate at one of our hospitals, at Hagedorn as -- since they did not have a RENNIE advocate. And, you know, the input we got from what we saw out of that process is there were helpful aspects to her role with her background as an APN, so that factored

in. So we started to develop this idea, that maybe as part of this hearing, this medication review hearing, in addition to having an independent panel, we could have these, you know, these semi-independent, APN level nurse practitioners or APNs involved with the setting up and these panels and, you know, working with the RENNIE advocates in terms of these issues. So that started to, you know, look to us like this would address some of these issues that I mentioned earlier with the RENNIE, you know, with this -- the need for the clinical input and also the imbalance of power, authority because you have the authority of the psychiatrist on one side and independent panel, but then you have the RENNIE advocate and, you know, helping the patient represent their views that we thought that this would certainly address some of that. So we started talking more seriously about this.

We started to say, well, would we have positions. We do have some APNs in our hospitals, but they don't fully practice as APNs. We have clinical nurse specialists who have the same training. So we felt we could -- we could have a

Master's level nurse fulfill this role and so we started talking more specifically about we should develop a position for this -- this role and call this -- not to confuse it with Client Service Representative, which we led on the idea of a Client Service Advocate.

Q So going back to the initial, I guess, goal of drafting the policy, was it always the -- was it always the intent of the working group that the policy would include what I think you've called a hearing review panel?

A I think we -- that was clearly our goal, to keep it a clinical process, clinically driven. And if we could have independent experts, the panel led by an independent psychiatrist, and other clinicians. And we have here clinician and an administrator who are not from the patient's unit, so that would be an independent, objective view, of the issues. And I think we started to think about the logistics of it, the additional staff, how we would -- I mean, since we've had problems, some issues, as we've talked about over the years of sometimes getting IPs, one of the issues, though, this would be a regular panel, whereas the IPs we

have now are just hired as needed. You know, it's episodic. But this would be in some ways relatively easier to ensure we could get IPs if we could do this on a more regular basis. So we factored that in and we started looking at where would we get these independent psychiatrists and how would we incorporate them in this role in the hospitals.

Q Is Exhibit 45 that you have the final version of the new policy or is it still undergoing revision?

A Well, I think it's probably going to undergo revisions. I think it's a draft we're using for now, but there will be -- as I mentioned, the one reason we want to roll it out incrementally by hospital is to understand what the issues are in the hospitals. This is -- I don't know if this kind of -- aside from what occurs currently in the Department of Corrections, I don't know of this policy or this specific policy being implemented anywhere, particularly the role of the Client Service Advocates, it's probably something that is unique. Although it is based -- the policy, the panels themselves are based on -- somewhat on what is occurring in the Department of Corrections.

psychiatrists. Again, I should know his exact title or role, but I met with him when I went to the prison, Trenton, in Trenton here to receive this process.

Q And so that meeting was between Dr. Kaldany; is that right?

A Kaldany, yeah.

Q Kaldany?

A Kaldany, K-A-L-D-A-N-Y, I believe.

Q Thank you. Was anyone else present besides the two of you?

A Well, there were the people in the unit who were doing the review. But we had a meeting prior to this, I should say, with Miss Sciaston and Miss Griffin with some of their other staff prior -- at Corrections about the procedure before. We wanted to ask them for their -- to look at their policies. We wanted to ask them whether we could, in fact, have the direct observation. And that was a meeting to set that up. And that was at the Department of Corrections in Trenton. So we -- we had that initial meeting and then we got the okay to have -- for Miss Griffin and I to individually go and see these -- these hearings take place.

Q Okay. So the question about whether you could have direct observations was whether you could go and observe at their own medication review hearings?

A That's correct.

Q And was the purpose of the meetings overall with the Department of Corrections to discuss the way that they handle involuntary medication of prisoners?

A To look at their policies to see if are any -- if their are aspects of their policies that would be -- that could be models and to understand how these hearings were held and to see these firsthand, yeah.

Q Did you receive copies of those policies?

A We did.

Q And what -- what issues about how they conducted medication review hearings did you discuss with Dr. Kaldany and his team?

A Well, I was interested to see how the hearings -- who was -- who was on the hearing panel, what notification and what prior activities took place prior to the hearing to develop, you know,

the -- to provide the documentation to notify the patient of the hearing, and just how the process was -- was managed, you know, before and after the hearings took place in addition to seeing what the hearings -- what happened at the hearings to see whether -- what kind of clinical issues they were addressing, whether there was similarities with our system and how, you know, what kind of due process, just in general, using that term, procedures took place and whether this was a model that was feasible or preferable in some way to what -- you know, what we've done with our three-step reviews.

Q And as to that last question, whether their model was feasible or preferable as to what DHS has done with its three-step reviews, how did you come out on that question or how did the working group come out on that issue?

A I think from our review of the policies and our observation, we didn't think their model was preferable to our process. However, we thought that with certain enhancements to that model we could develop a procedure that potentially was preferable to what we have been doing. It would require a number of changes. And these are the changes to the

We were talking about enhancements that the working group thought might work in the context of DHS hearings and I think you mentioned the presence of a RENNIE advocate, the presence of a independent psychiatrist, a panel decision, and well trained staff to participate on that panel. Did I get them all right?

A That's correct.

Q So the RENNIE advocate, is that a position where there was -- for the Department of Corrections process, is there no RENNIE advocate or equivalent involved?

A That's correct. There is no -- as I understand it, there is no equivalent. What they have is staff persons or social workers who may -- who give notification to the patient and there's not a representative of a position or a person who is primarily responsible to be the patient advocate in that. They may have a role in the hearing as an advocate, but they don't have an independent -- you know, a staff member, whether clinician or not, who -- is my understanding, taking on that role. And that's what I felt, if we had that, that would improve the process.

A Sorry.

Q Are there differences between the CSA and the social worker who is used over on the DOC side, other than clinical training?

A I think there is a difference in that we're talking about a person dedicated to this role who has the Client Service Representative, the RENNIE advocate report to them, so we have two staff, one of whom is responsible for initially meeting with the patient, talking to the patient, educating the patient about the process. That would be the Client Service Representative or RENNIE advocate. And a clinician who has a background in understanding of psychopharmacology and who fully understands the clinical issues involved in medicating people with psychotropic medications working together with a panel, an independent panel, to ensure that, you know, the appropriate decision is made that, you know, was in the best interest of the patient and also represents their -- their concerns. I think that's what we're trying to meld together here. It's a process that will enhance what we're currently doing.

Q Are there any other changes that DHS

Q Do you know or was there any discussion of how I guess the folks at the psychiatric hospitals will determine whether there's a likelihood of serious harm to self, others, or property without medication?

A Well, again, this is going to be part of our training. We expect that we're going to be talking using vignettes, using a much more detailed discussion. We -- the harm, as we understand it, is in the reasonably foreseeable future. It's not the same standard as the emergency medication standard of imminent or impending danger. It's in the immediate future. And it should have been evidenced, as we say in our standard, by some either threat or behavior that suggests the person is placing themselves or others at risk or that their clinical condition is deteriorating to such that they'll be unharmed. You know, or there is destruction of property, for example. There has to be -- we'll have -- we'll have to provide details and discussion. I mean, that's been a concern that we are changing a standard, as well as a process here. That is a significant change with the policy.

Q You mentioned training materials on

this. Have there been any training materials drafted on this new policy?

A No, there have not.

Q On the standard we were just discussing, serious harm to self, others, or property without medication, can it be based on past behavior of a patient?

MR. LEYHANE: Object to form.

BY MS. WELLS:

Q As opposed to current behavior.

A I think the past behavior factors in, but it's not the primary consideration. It's the current clinical status. Past behavior is always predictive of future behavior -- future violence. It's a -- you can't remove that factor.

Q Is it fair to say, then, that under this standard it would be appropriate for the treating psychiatrist to review or refer to other incidents in the patient's medical records in making this determination?

A I think it would be fair to say that incidents that are of recent or that current behaviors that are similar to past behaviors where there was violence occurring would be factored in

and would be considered in that definition of the criteria for reasonably foreseeable future for a prediction.

Q Is the idea that recent behaviors or current behaviors would be properly factored in and documented in the policy, as opposed to behaviors that could have happened a month ago, or a year ago, or 10 years ago?

A I would think that would be -- that would certainly be a factor, yes. We would want to see more -- similar to the commitment standard, we would want to see more recent behaviors and again, you know, that's a general rule, but certainly we have individuals who under certain conditions with certain symptoms or behaviors indicate an underlying psychotic process that could be leading to violence, even though they have not demonstrated this outwardly. There are -- there are situations where that occurs.

Q I think I may have asked an unclear question. What I was trying to get at is, is that notion that it's appropriate to look at more recent behavior as opposed to older behavior actually written into the policy anywhere?

BY MS. WELLS:

Q Okay, Dr. Eilers, welcome back from lunch.

Before we took our break, we were discussing the DHS proposed policy that will replace AB:504, which has been marked Exhibit 45. I think you still have that in front of you; is that right?

A Yes.

Q I'd like to turn to the definition section. The first defined term is Client Service Advocate. My first question about this is, the definition appears to say that the CSA will report directly to the CEO or Deputy CEO of each hospital and to the Medical Director through the Coordinating Chief of Client Services Advocates.

Is that correct?

A That's correct.

Q Okay. So my first question is, is there a direct reporting relationship to both the hospital staff, the CEO or Deputy CEO, and up through the Coordinating Chief of Client Services or is there a dotted line report to one?

A There's a direct report to the CEO and a dotted line reporting to the Coordinating Chief of

A Well, their responsibilities -- and again, this is all new, but I think we put in the policy that they should report these to the Medical Director. However, I would also see that they would address them directly with the treating psychiatrist and the treatment team. But they will -- they will be working closely with the Medical Director and I suspect the Medical Director would -- as we have -- I mentioned here, the biweekly reports coming in from the treating psychiatrists. They will be working -- they will be looking at these biweekly reports and they will be conferring with the Medical Director with any patient they have concerns about.

Q In the event that there are -- I guess if the CSA observes that the medicine isn't effective or there are side effects, is there any kind of formal review that is triggered by that observation? Because we're talking right now about patients who have already been involuntarily medicated, correct?

A That's correct.

Q So would there be any review that's triggered by those observations that there are negative side effects from the medicines?

would be some kind of formal or official or even unofficial review, if the CSA observed side effects or that the medication was ineffective, that's not written into the policy?

A That's not written into the policy I don't believe right now. Yeah, I would have to agree with that.

Q Are CSAs charged with advocating for the express preferences of their patients who were involuntarily medicated or subject to that?

A Again, we talked about this with the RENNIE advocate and I think it's -- it's a similar role. They're advocating in as far as they want to have the patient's preferences, values, concerns about medication at least expressed to the panel, to the Medical Director. There is certainly in that a degree of advocacy, but they're also clinicians and so they're going to be evaluating the person's clinical response or clinical needs as well. But I would say -- I would say because we are calling them Client Service Advocates and that is an aspect of their role, yes.

Q Is it the case that if the observations of the CSA from a clinical perspective is somehow

Q -- if he or she is determined that medication is appropriate?

A I'm sorry, yes. You're talking about before.

Q So before initiating that procedure, is there any requirement that there be a meeting with the patient before the procedure is implemented?

A I mean, we didn't spell it out here, but I think that's certainly -- that's a requirement, that there always is a requirement that the -- when the psychiatrist is meeting with the patient as part of their -- you know, whatever aspect of the -- where they are in the treatment and they're making a recommendation for a medication and they're explaining the -- why they feel the medication is necessary, why -- what are the risks, what are the side effects, what, if any, alternatives exist, and what would happen should they -- the patient not consent, that they have -- they can talk to the RENNIE advocate. All of that, I would assume, still would exist under this new -- under this new procedure.

Q But is it correct that it's your understanding that that's not explicitly stated in

the policy?

A I don't see it explicitly stated, that's correct.

Q So, for example, if the treating prescriber was -- had a day off and came back on duty and a nurse or someone else reported that the patient engaged in some kind of behavior that they believed made -- presented a likelihood of serious harm to self, others or property, would the treating physician need to meet with that patient again in order to implement the policy or could they rely on the word of the other doctor, the nurse, or the staff member?

A No, I would expect them, that they would have to meet with the patient. I think the policy -- we can't -- the engagement of the patient with the treating psychiatrist regarding the medications and the options available, to me is without -- goes without saying, that that has to be part of the policy, and it can't be the decision to refer, complete an IMR should be made based on some information that that subsequent psychiatrist hears or reads in the chart I don't think is appropriate. I think -- I think -- and again, we can flesh out

the details, particularly in completing this IMR. The IMR, I believe, requires -- it's going to require a face to face, and it's going to require that all of these alternatives are discussed with the patient, that they discussed alternatives. They discussed less restrictive. They discussed the treatment that's proposed, the side effects of the treatment, any other issues that the patient has a concern, that all would be built into this and I know it doesn't say it here, but I'm positive that with -- that is a requirement here.

Q The next paragraph mentions an involuntary medication administration report. Do you call that -- what do you guys refer to that as, if anything? Is there a shorthand -- is it IMAR or is it IMR is what I'm really asking? Or is it something?

A Well, we're referring to this as the IMAR. The first section of the report, which goes to the panel with the recommendation from the treating psychiatrist, that's the IMAR.

Q Is there a draft of that form that's been created?

A I believe there is.

weekend or a holiday somewhere in the middle?

A That's correct.

Q Then it also says that the Client Services Advocate and the patient will be provided with notice of the hearing and the IMAR form at least two business days prior to the hearing date.

Do you see that?

A Yes.

Q Is there a reason that there's a gap -- if the hearing is going to take place five days out, is there a reason that the form needs to be -- and the notice needs to be transmitted to the CSA and the patient only two days before?

A You know, I don't remember the reasons for putting the timeframe in here for the two business days and that gap, as you mentioned. I understand there needs to be an evaluation in that period of time, the CSA has to be involved, and I don't know if that's -- if that's the reason this is put in here, but there needs to be some time in order to -- first there needs to be time to schedule a hearing, that's one issue with the five business days, getting these independent panelists scheduled. And I would hope then the CSA is involved. But as

words, --

MS. WELLS: I've heard your objection.

You can answer, Dr. Eilers.

THE WITNESS: Well, we're saying here that the standard is, you know, dangerousness so far in the reasonably foreseeable future, and again we're not talking about an emergent need for medication. So that is why hopefully with this procedure in place, patients -- there will be a limited -- there will be a time period in which the patient will not necessarily receive medication, unless they meet the standard for the emergent medication.

BY MS. WELLS:

Q If you look to paragraph letter I, it says, The medication review hearing shall take place on the patient's unit.

Do you see that?

A Yes.

Q Was there any consideration of doing the hearings in a location other than the patient's unit?

A I don't recall any discussion about doing these hearings elsewhere. There certainly may

connection with the involuntary medication process, do you recall generally that discussion?

A Yes.

Q You said that one of the concerns that you had was that it could interfere with the doctor-patient relationship; is that correct?

A That's correct.

Q Is it your understanding that for commitment hearings that the treating physician and potentially other hospital employees will testify at those hearings?

A That's correct.

Q Does that interfere with the doctor-patient relationship?

A It does at times, yes. In some cases there are hospitals that have individuals doing hearings that are not affiliated with the treatment team to offset that issue. In our system it's -- that's not possible. We need to have a -- someone present who is knowledgeable of the patient and that is the treating psychiatrist. But it doesn't -- it does lead to tension and sometimes, you know, interferes with the treatment process when we have someone who is providing their treatment, who they

different because of the fact that, at least in our setting, people are admitted -- they're committed to treatment against their will. Oftentimes the treatment requires them to receive psychiatric medication. It's a common -- a more common necessity or a practice given the nature of that commitment and their placement in the hospital. And I think there needs to be a process, for example, such as a special medical guardian for people who -- even though we are getting guardians right now for people who are not able to consent for psychotropic medication, as I mentioned earlier, I think there is a very common situation of patients presenting with the likelihood of being dangerous to themselves or others if they are not medicated and I think there has to be in place a process to allow that determination for medication to be made that is more -- you know, is more available, if needed, for staff and the patients in order to provide a safe environment, and meet the patient's treatment needs. So I'm just saying I think it's hard to compare the medication issues for medical issues like diabetes or other kinds of conditions with that of somebody who is -- who is admitted for -- for treatment

they're committed there for a psychiatric illness as a result of being deemed dangerous to self or others, they're more likely to need a medical -- a psychiatric treatment on a -- as a primary focus of that care and therefore, I think the procedures, comparing one to the other, I was just suggesting there is a different purpose for or -- and frequency of need for a procedure that allows psychotropic medication, non-consentually.

BY MS. WELLS:

Q I think --

A I tried to explain that several times, but --

Q I think we may be talking past each other.

A Yeah.

Q We discussed a moment ago that there were -- there were only two circumstances in which someone who needs medical treatment can be forcibly medicated. And there are more circumstances than just those two under which someone can be involuntarily given psychotropic medicine under AB:504 and under the proposed policy, fair enough?

psychiatric hospital, needs psychiatric treatment, affects what circumstances someone can be involuntarily medicated. In other words, why are there more circumstances for the psychotropic involuntary medication?

MR. LEYHANE: You know, objection to form. You've been through this a number of times. I don't know how many times he can explain it. Everybody else is getting it, but I think you want a different answer and you're not getting it.

MS. WELLS: I will respectfully disagree that I don't think this question has not been answered yet and it may be because I'm asking bad questions.

THE WITNESS: I was trying to answer it in that I see a different reason for the person being in the hospital and needing that treatment. They're not there because they have a -- they're not there because they have a chronic liver condition and therefore need, you know, certain medications or certain tests. That's secondary. They're there because their behavior or their symptoms are

such that they put themselves or others in danger, and that hopefully they're there to receive appropriate treatment, which includes medication and medication is a very common -- it's a common treatment for these conditions. It's a primary treatment. It's part of our treatment plans. And oftentimes patients who are involuntarily committed do not agree with that commitment or with the treatment. And I think it's a -- we tend to see this as a more of a -- of an issue that we -- you know, that needs to be addressed from a clinical nature, at least, on a daily basis. And having a procedure which is clinically driven that can allow medication to be given safely and when it's appropriate in a psychiatric hospital where you don't have to resort to a legal process seems a good idea. Comparing it -- comparing it to our procedures for medical -- overriding medical consent is, to me, not a good comparison because, you know, basically we -- we have adequate processes to get that treatment elsewhere or if it needs to be provided in our hospital. In our hospitals we

do have most of the time a means to provide it legally. The issue we have not dealt with over the years so well is the -- the refusals that occur for more of the non-invasive type treatments that we need that patients refuse that we tend not to provide because they have refused. But when there is a need to provide a more invasive kinds of treatment because of the seriousness of the consequences we, you know, we can't provide that.

BY MS. WELLS:

Q One of the factors that you mentioned earlier was dangerousness to themselves or others.

Do you recall that?

A Yes.

Q Why is that, in your view, a reason that there can be a difference in involuntary medication procedure for psychotropic medication versus medical treatment?

A Well, I think in the case of some individuals with mental illness who have the potential or where there is a likelihood of danger to themselves -- to self, or to others, there occasionally or frequently -- not frequently maybe,